Testimony of
Robert E. Hertzka, MD, President,
California Medical Association

August 20, 2004

CPR Commissioners, Governor Schwarzenegger's Staff, colleagues on this Provider Panel, Ladies and Gentlemen, I bring you greetings from the California Medical Association.

To those who worked on the California Performance Report, we offer our compliments and thank you for the incredible work you have produced. As citizens and taxpayers of the great state of California, physicians of the California Medical Association share your goals of putting the people first, streamlining operations, saving taxpayer dollars and creating value for dollars spent.

We are pleased to be here today to offer testimony. We realize this report is a work in process that will continue to be refined through public review and input. As with so many things, the "Devil is in the details". We may find our thoughts changing as more information becomes available and offer our continued efforts to achieve an effective, efficient state government for us and for our fellow citizens.

To start with recommendations we find laudable – we agree that fragmented responsibility and duplicative functions should be consolidated where the best skills and processes can be effectively applied. We strongly urge the use wherever possible of automation – in eligibility processing, in provider enrollment, in authorizing and paying for services to Medi-Cal, Workers' Compensation and other governmental program patients. We have long pressed for improved coordination of our public health system and are thrilled to see the recommendation to create the position of State Public Health Officer. (Now we challenge you to fill – and adequately compensate -- that position with a highly trained and effective physician leader, such as Dr. Jackson who has been named as the Public Health Officer in DHS.) We support consolidation of programs such as mental health and alcohol and drug programs so long as the final program is adequately funded. We also really like revising the Medi-Cal provider enrollment process to eliminate procedures that add cost without value in protecting against fraud.

As owners of small businesses, California physicians strongly urge the simplification and consolidation of business licensing functions and we really like requirements for prompt service and prompt payment.

So, in these recommendations, there is much to like.

Now, I'd like to focus on areas where CMA does not think we've quite hit the mark.

1. CMA has not been shy about demanding more aggressive enforcement of payer abuses. We support the transfer of the Department for Managed Health Care's ("DMHC") functions to the DHHS but suggest these recommendations do not go far enough. We encourage a fundamental reexamination of how all health insurance is regulated, whether that insurance pays through capitation or through fee for service methods. The proposed placement of DMHC functions in the Center for Quality Assurance may not effectively address the financial solvency, claims payment, contracting, and other purely insurance functions that underlay the scope of regulatory activity we believe is mandated by the law. CMA believes that the regulation of health plans should fall within a separate stand-alone entity, one with not only quality assurance expertise, but also financial and enforcement expertise. We would be pleased to have this entity exist within the Department of Health and Human Services. On the matter of eliminating the Managed Care Advisory Committee and Clinical Advisory Panel, we believe there must be a process for obtaining and incorporating meaningful input from experts. Without such stakeholder input, the regulations proposed often further burden both the government and public without creating efficiency.

2. CPR proposes to merge the licensing functions of the Medical Board of California into DHHS and move enforcement functions into Public Safety and Homeland Security. We believe there is value in combining health entity licensing into a global quality division and support such a change. We believe, however, that there are important reasons to continue to have an oversight board, the majority of whose membership is physicians, that is capable of providing the unique expertise necessary to oversee the rapid evolution of medical practice. Retaining such a board does not impose a burden on taxpayers, since the costs of board member participation is paid out of licensure fees.

3. On the matter of assigning medical license enforcement functions to Homeland Security we make the following observation: We would rather have nurses with two weeks of police training than police with two weeks of medical training responsible for combing through medical information and preparing reports for medical-legal experts to determine whether the standard of care is met. CPR language suggests that medical licensure enforcement be assigned to Homeland Security because current personnel are "sworn peace officers" who "carry guns". We say, take away the guns! Refocus this effort with appropriately trained clinical personnel – probably at a savings. They can call in police if there is ever an occasion when guns are deemed necessary.

4. CMA is supportive of consolidating hospital licensure in a single department, but is very concerned about the survey process and standards that may be employed. Noting both the negative GAO report about existing hospital accreditation shortcomings and the fact that the national accreditation standards do not include standards that clearly assure that physicians retain oversight over medical care decision-making, we continue to press for retaining a process such as the Consolidated Accreditation and Licensure Survey ("CALS"). We also urge the involvement of the Institute for Medical Quality in this process.

5. CMA is very concerned with the proposal to eliminate Emergency Medical Services Administration ("EMSA"). While there may be some elements of EMSA functions that relate to emergency preparedness, a great portion of their responsibility concerns the day to day needs of the average Californian who experiences a heart attack or is involved in a car wreck. Response to these person specific events is a very different issue than responding to a public disaster. We greatly fear that trauma and emergency personnel and their programs will not receive the attention they require in a department dominated by enforcement and emergency preparedness programs. We believe this entity should be placed where it can continue to support provision of these necessary medical services.

6. CPR proposes to consolidate health care licensing functions. CMA believes that further streamlining can be achieved by removing duplicative State oversight and fee assessments for clinical laboratories --especially those laboratories that are owned and operated by physicians in order to assure access to laboratory services for their own patients. These laboratories are already assessed fees and are well regulated under the Federal Clinical Laboratories Improvement Act (CLIA). Additional State oversight is unnecessary.

7. CMA understands why there may be value in elimination of MRMIB. However, we have great respect for that organization's skills in contracting and providing program oversight. We would encourage DHHS to replicate the models and approaches developed by MRMIB.

CMA has already provided extensive comments on CPR recommendations and will continue to provide input as these recommendations and CMA's understanding continues to develop. We do want to point out one missed opportunity before we close.

There are multiple references to information technology in various portions of the report. One proposes to introduce "Smart Card" technology. We believe that and similar recommendations fail to recognize the benefit of moving toward an electronic health record and data sharing process that could bring together the clinical data associated with the care of patients covered through state funded programs. In keeping with the movement toward a health information infrastructure occurring at the national level, CMA believes that capture and exchange of clinical data improves quality of care, increases patient safety, reduces cost and helps eliminate fraud. Demonstrations in other states clearly indicate enormous savings from implementing such approaches. We urge CPR to incorporate this broader concept in its considerations.

Thank you for your attention and time to hear our remarks. CPR Commission Members, I stand eager to answer your questions.

Respectfully Submitted on behalf of California Medical Association by

- Robert E. Hertzka, M.D.